HRTO FILE 2013-16149-I

HUMAN RIGHTS TRIBUNAL OF ONTARIO

ASSOCIATION OF ONTARIO MIDWIVES

Applicants

v.

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO AS REPRESENTED BY THE MINISTER OF HEALTH AND LONG-TERM CARE

Respondent

AFFIDAVIT OF ELIZABETH BRANDEIS

I, Elizabeth Brandeis, of the City of Toronto, in the Province of Ontario, MAKE OATH AND AFFIRM as follows:

1. I am the current President of the Association of Ontario Midwives, a Ryerson Midwifery Education Program Lecturer and a practising midwife with the Midwives Collective of Toronto since 2003.

2. My background, knowledge and experience which support the statements in this Affidavit are set out in my Curriculum Vitae[1] and summarized in Part 1 below. This affidavit constitutes the main section of my examination in chief in this proceeding.

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1 Curriculum Vitae of Elizabeth Brandeis, AOM0016609.

I. BACKGROUND

1. Education And Knowledge

3. My education and knowledge arises from several areas of learning and degrees.

4. In 2013, I obtained my Masters of Science in Community Health from the University of Toronto Dalla Lana School of Public Health/Department of Family and Community Medicine. My degree focused on health practitioner teacher education and inter professional education and practice.

5. In 2003 I graduated from the Ryerson University Midwifery Education Program with a Bachelor of Health Science in Midwifery with Honours.

6. From 1990 to 1997 I completed two university years in Humanities, Arts, and Social Sciences at: Columbia College, Chicago; New College of California, San Francisco and thereafter while caring for my child and working part time in the restaurant industry took courses at Queen's University and University of Toronto.

2. Practising Midwife

7. I have been practicing midwifery since 2003 with hospital privileges initially at Women's College Hospital and Mount Sinai Hospital, Toronto jointly and only at Mount Sinai since 2005. In 2006 I became a partner midwife at the Midwives Collective of Toronto. I have been a preceptor of midwifery students since 2005.

3. Maternity Care Instructor for Midwifery, Physician And Nursing Students/Colleagues

8. I am an occasional part time faculty Instructor in the Midwifery Education Program at Ryerson University where I have lectured on topics ranging from Midwifery Clinical Skills to Midwifery Issues and Normal Childbearing.

9. I taught in the Ryerson MEP Clinical Skills Intensives and Emergency Skills Workshops from 2008-2010. I also taught the Refresher in Primary Maternity Care Conference, convened by the Mount Sinai Department of Family Medicine for many years, presenting with physicians and nurses on a variety of topics including fetal health surveillance, perineal repair and communicating difficult topics such as fetal demise.

10. As well, I have provided workshops for University of Toronto obstetrical residents on the midwifery model of care and on consultation with obstetricians.

11. As well, I am an experienced maternity care clinical instructor in the hospital context. For example, I have been a core team member of the Managing Obstetrical Risk Effectively (MORE^{OB}) Program at Mount Sinai Hospital since 2008. In that role, I acted as an inter-professional Education instructor for medical, nursing and midwifery staff at Mount Sinai Hospital.

12. As well, I have presented rounds at Mount Sinai Hospital on the following topics:

    (a) data from the Midwifery Outcomes Report in January, 2010;

(b) on Midwifery Clinical Practice Guidelines (Do Midwives Do Things Differently?) in 2011; and

(c) on Waterbirth in 2015.

13. I have also presented on waterbirth at the Society of Obstetricians and Gynecologists of Canada (SOGC) Toronto meeting in December 2014 and at the Primary Maternity Care Refresher Conference at Mount Sinai in 2015 and the College of Family Physicians of Canada Forum in 2015.

4. Consumer Advocate

14. My introduction to midwifery started back in 1994. At that time I had my baby with the assistance of a newly registered Guelph midwife who practiced pre-regulation.

15. This interest led to my becoming a board member of the Ontario Midwifery Consumer Network (OMCN), an organization of midwifery consumers which helped to support midwifery integration after regulation. (formerly known as the Midwifery Task Force of Ontario (MTFO).

16. Our advocacy for respect and integration of midwifery as a female dominated profession was rooted in feminism and Ontario's women's movement which was advocating for women's equality on many different fronts, including equitable health care and reproductive choices.

5. AOM/CAM Leader

17. Over the years since 2009, I have taken an active leadership role in the Association of Ontario Midwives (AOM) and the Canadian Association of Midwives (CAM).

18. I joined the AOM Executive Board as a member at large in 2009. At that time Katrina Kilroy was the AOM President. Subsequently in 2011, I became Vice President, in 2015, I became President-Elect and I assumed the presidency this past May, 2016. I was involved directly in AOM MOHLTC funding negotiations from 2012 onwards.

19. I have taken an active role in many of the AOM committees including the AOM's Liaison Committee with the OMA. I also chaired the AOM's Policy Committee since 2009. I participated in the Hospital Integration of Midwives Work Group which the MOHLTC convened from 2014-2015.

20. From 2009-2012 and as well currently, I am the CAM representative to the College of Family Physicians of Canada's Maternal Newborn Care Committee. I am the Ontario representative on the CAM board since Oct 2015.

6. Midwifery Hospital Leadership and Inter Professional Collaboration

21. I have taken a number of leadership roles at Mount Sinai Hospital aimed at improving maternal and newborn care.

22. In 2008, I founded a Nursing and Midwifery Liaison Committee at the Hospital in 2008 which operated for a number of years. I was a member of the Hospital's 2014 Normal Birth Task Force which set up guidelines for practices which supported normal birth in the hospital.

23. From 2009 – 2010 I was the Head Midwife at Mount Sinai Hospital.

7. Feminist and Mother

24. I moved to Canada in 1992 from the United States. I continued in Canada my interest as a feminist and now mother in women's equality, anti-oppression frameworks and health equity issues. My women's studies course at Queen's in 1995-96 focused on women's equality issues including systemic discrimination and pay equity. I was also a volunteer at a sexual assault crisis centre and provided peer to peer counselling for survivors.

II. PURSUING MIDWIFERY AS A PROFESSION

1. Midwifery Education Program(MEP)

25. After I decided I wanted to be a midwife, I took a number of steps to try to further my chances of getting acceptance to the Midwifery Education Program (MEP) as it was known be very competitive with some applicants have to apply a number of times. I participated in a self-study group of other applicants to practice for the interview process. I also volunteered as a labour support person to pregnant teens and then co-ordinated the volunteers.

26. I found the course to be quite intensive, particularly the clinical requirements in the last two years when I was unable to work and earn money.

2. New Registrant Year

27. After graduating from the MEP and passing clerkship exams, I started my New Registrant Year at the Midwives Collective of Toronto. During this year, I continued my clinical training with being actively mentored by the senior midwives in my practice, namely Vicki Van Wagner, Katrina Kilroy and Elizabeth Allemang.

III. PRACTISING MIDWIFERY

28. During my first years of practising, I concentrated on developing my clinical skills as a primary care provider. This included learning full scope midwifery practised

in an autonomous context. I found the work to be challenging and demanding as well as fulfilling as I helped women make empowering health care choices.

29. During the initial years of practising midwifery, I was struck by its low compensation, given the years of time and money I had invested in my midwifery education and registration, and the immense responsibility and intensive work I now experienced.

30. The demands and working conditions of my midwifery practise are very onerous I was fortunate to have a teacher as a partner who was able to care for my daughter outside of school time and so I did not have night child care costs as many midwives do with children. I recall a new midwife in our practice deciding to leave midwifery when she was pregnant and single. She decided to go to medical school and became a family physician which gave her more income and less on call requirements.

IV. EXCELLENT MIDWIFERY OUTCOMES

31. As I started practising midwifery, I observed in practise the excellent midwifery outcomes for clients and newborns which I had learned about in the MEP. Holliday Tyson had published her paper, 1001 Home Births in Ontario, which detailed the good outcomes pre-regulation.[2] Since then, there have been various reports which have noted the excellent outcomes of midwifery, including the MOHTLC Evaluation of the OMP which was presented at our May 2004 AGM.[3]

32. The 2006 Provincial Perinatal Report was released and again detailed the excellent health outcomes that midwives were achieving for women and their newborns.[4] As well, during that year, the Ministry released data that showed midwives continued to produce excellent outcomes on a number of maternity care indicators.[5] experience of gendered disadvantage and prejudice

33. My perception and experience of the role that sex and gender has played is informed by the systemic disadvantages I experience in the context of my being part of a small group of midwives in the hospital setting at Mount Sinai.

34. Mount Sinai Hospital like other hospitals has systems which place physicians in the dominant role, exercising significant control and influence. The department heads for Family Medicine and Obstetrics were male. While the obstetricians

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2 Holliday Tyson, 1991, Outcomes of a 1001 Midwife Attended Home Births in Toronto (1983-1988) AOM0017373.

3 Presentation of the MOHLTC to AOM re: Ontario Midwifery Program Evaluation (May 13 2004) AOM0001370.

4 Provincial Perinatal Surveillance System Committee, "Tailoring Services to Pregnant Women and their Babies in Ontario: 2006 Provincial Perinatal Report" (2006) AOM0000651.

5 Ontario, "Ontario Midwifery Program, Ministry of Health and Long-Term Care: Ontario Midwifery Clinical Database". APHEO Conference (October 16-17, 2006) AOM0000603.

generally were approximately evenly distributed by gender, the Maternal Fetal Medicine Specialists, which are a subset of obstetricians, were highly male.

35. The gendered context also arises because I advocate as a woman on behalf of my female clients and their newborn children.

36. It is in the hospital setting where I experienced systemic disadvantages compared to my obstetrical colleagues who also provide maternity care there. In particular:

    (a) At Mount Sinai there are hospital caps on midwifery courses of care. About 85% of the births at Mount Sinai are done by OBs with most of those being low risk. This distribution of work and the caps mean that the Collective must turn away a substantial number of potential women who could otherwise receive midwifery care and improve the Hospital's maternity care outcomes;

    (b) The Head Midwife has no official standing and requests to have an official direct line to management have not been successful. The position is not paid whereas the Physician Heads are paid;

    (c) There is no direct channel for the head midwife to report to management although we have asked for one. Instead, the system is structured so that a physician - the Chief of Family Medicine department, is supposed to represent the interests of midwives at the Hospital.

    (d) This results in midwives' ideas for addressing issues re: pregnant women at hospital often not being listened to appropriately and given respectful attention and consideration: For example a request to use midwives at Mount Sinai to improve work flow was rejected;

37. All of the above leads to my feeling that midwives such as myself are often just a guest in someone else's house and this impacts my professional autonomy and self-worth and respect. I believe this creates an atmosphere which works to justify our lower pay, given the systems which accord us lower status.

38. Midwives still face significant barriers in their practices. Some hospital Medical Advisory Committees (MACs) continue to deny privileges to registered midwives and hospital department and physician policies restrict the scope of midwives as defined by legislation and the CMO.

39. OB departments often direct hospitals to restrict how a midwife can practice, resulting in midwives not being permitted to maintain primary care where an epidural is required or chosen or when oxytocin infusions are required for inductions or augmentations. It is my observation and experience that these restrictions are not based in medical need, nor are they evidence based.

40. Despite the mandate of the OMP to facilitate the equitable integration of midwives, the Ministry has not acted to sufficiently address these structural barriers leaving midwives to face these systemic barriers. This has lead, in my observations, to:

    (a) a resultant potential decrease to patient safety,

    (b) reduced access to midwifery care,

    (c) and increased costs to the health-care system due to double payment to the physicians for work midwives are already paid to do.

41. I have observed that these medically unnecessary transfers of care interfere with a woman's right to a midwife as her primary care provider during a low risk labour and birth, as a result of hospital policies set by the hospital departments which are not evidence-based, motivated by safety, nor patient-centred. This violates the premise that childbearing belongs to the woman, and that she is the primary decision maker for her care.[6] More importantly, these medically unnecessary transfers of care have the potential to decrease patient safety, as evidence demonstrates that each transfer of care increases the likelihood for communications breakdown, thereby potentially compromising care.[7] All of the above actions or omissions have meant that the midwives such as my colleagues and I remain structurally and procedurally subordinate to physicians and has contributed to the failure to appropriately recognize the expertise and value of the female midwives.

42. In light of these concerns, the AOM prepared a 2011 document, Maintaining Primary Care for Clients Who Access Induction, Augmentation or Epidural. [8] This document called for midwives to be enabled to work to the scope of practice outlined in the Midwifery Act and by the College of Midwives of Ontario (CMO) which includes retaining primary care for the administration of oxytocin for induction and augmentation, the monitoring and maintaining of epidural analgesia, and the administration of cervical ripening methods, including prostaglandin gel and Foley catheters. Enabling midwives to maintain care in these situations simply means enabling midwives to practice within the current regulatory framework. The document also highlighted the benefits and documented research for such an approach, namely that it 1) minimizes medically unnecessary transfers of care; 2) maximizes the efficient use of health

6 AOM Report titled "Maintaining Primary Care for Clients Who Access Induction, Augmentation or Epidural" (2011) AOM0000612.

7 AOM Report titled "Maintaining Primary Care for Clients Who Access Induction, Augmentation or Epidural" (2011) AOM0000612.

8 AOM Report titled "Maintaining Primary Care for Clients Who Access Induction, Augmentation or Epidural" (2011) AOM0000612.

care resources; 3) fosters inter professional relationships and respect; and 4) assists compliance with the *Excellent Care For All Act (ECFAA).*

43. *As well, these unnecessary transfers lead to the MOHLTC paying physicians for work which they have already paid midwives to do. The fact that the MOHLTC continues to allow this double payment to occur is very frustrating since it favours physician's increasing their incomes at the same time that midwives are told the Ministry has to freeze midwives pay and can't afford to make equity adjustments.*

V. CHANGING WORK AND SCOPE OF PRACTICE OF MIDWIVES

1. Introduction

44. I studied midwifery and joined the profession of midwifery at a time when midwives' skill, effort, responsibility and working conditions were constantly increasing while they continued their significant contributions to the development of midwifery services and primary health care in Ontario.

2. Increasing Scope of Practice

45. During the period 2001 to 2004, as an example, there was an increase in the types of genetic testing offered to clients and consequently more screening and counselling; increased non-clinical issues as well as reporting responsibilities; more data and reporting requirements and accountabilities; and increases in human resources and practice management issues as practice groups increased in size and complexity.

46. During the period from 2004 to 2008, the specialized skills the midwives had were increasing as they were now able to assist at C-sections, amongst other matters which are detailed in the Durber Report - Annex 5 B and Annex 7.

47. C-section assists are provided by midwives, and provide a vital service by ensuring birth services are kept in small rural communities, and yet midwives have never been paid for this service, despite requests from the AOM to develop a funding mechanism for this additional specialized skill.

3. Changing Workloads

48. In 2007 I participated in the workload analysis survey which was initiated by the AOM. I, along with other midwives, charted the time spent in providing midwifery services. Although I knew that we were doing increasing amounts of work, when I actually broke it down into components I was surprised at how many hours our responsibilities took and what a diverse number of tasks (clinical, administrative and reporting and data responsibilities). I remember feeling even more underpaid and taken advantage of by the Ministry when it was broken down like this.

49. Through a comprehensive workload survey, the AOM determined that midwives in 2007 were working an average of 55.48 hours per course of care. [9] The consultants found that many clinical and non-clinical responsibilities had been added to the work of an Ontario midwife since 1993 such as: arranging Integrated Prenatal Screening (IPS) Genetic Screening; more informed choice discussions regarding, group B streptococcus, glucose screening, vaginal birth after C-section, and Vitamin K; administering home births infant health cards; increased provincial privacy requirements; increased requirements for invoicing; challenges in obtaining hospital privileges for practice members and advocating for the removal of restrictions on the practice; changes to accountability requirements from the province; changes to head midwife administration, monitoring and securing of infant health cards.

50. This means that midwives were working approximately 7.0 hours of unpaid work per client ("per course of care") in 2007 compared to 1993.

51. As well, we were expected to incorporate the Newborn Hearing Screening program into our practice around this time. This was an additional clinical and administrative and technical responsibility (managing the hearing screen machines) for which were not compensated at all. This task has now been removed as it has been decided that it should be performed by others who have updated equipment available to them.

52. In April 2012, the Ministry's MOR database was replaced by the Better Outcomes Registry Network ("BORN") database. The database collects extensive data from each course of care, and it was by the Ministry to monitor outcomes and ensure accountability. Although BORN collects data from all maternal newborn care providers, midwives remain the only profession whose payment of invoices is contingent on the submission of data to (previously) MOR and (currently) BORN. As well, the increased reporting requirements were not being accounted for in our midwifery compensation.

53. BORN data entries constitute at least 30 minutes of additional administrative work for every course of care (as well as for cases we cannot bill for, i.e. miscarriages) This new responsibility alone constitutes probably 20-24 hours of unpaid work.

VI. INCREASING ADVOCACY WORK FOR VULNERABLE CLIENTS

54. As our clients have become more diverse, our advocacy workload has increased substantially. I am often involved in advocacy for housing and food security, accessing mental health services, helping develop safe exit strategies for survivors of domestic abuse, workplace and even human rights abuses. This load of unpaid, complex and high-stakes work has significantly increased. As

9 Chart: Ontario Midwifery Workload, 1993 Historical Benchmark and 2007 Workload Analysis (2007) AOM0001033

well, our work with uninsured clients has also increased. Midwives and CHC staff are mandated by the MOHLTC to provide services for uninsured clients. These clients, who may be refugees or migrants are highly vulnerable, often with complex cultural and health needs. pursuing hospital integration and removal of barriers

1. Introduction

55. Hospital integration in general has been a major theme for my entire career.

56. At Mount Sinai, there are some systems which support midwifery autonomy and full scope of practice. For example, midwives have always maintained primary care for clients who have epidurals or need oxytocin infusions. These systems were developed at Toronto General Hospital in the 1990's and then adopted when the TGH obstetrical department merged with Mount Sinai's.

2. Hospital Systems and Midwifery

57. As noted above in Part V above, I have experienced hospital systems as being discriminatory toward midwives. While the MOHLTC does not directly control those systems, the MOHLTC does have systems and laws in place to direct or influence what hospitals do and they exercise those powers when they want to. For example the above noted, *Excellent Care for All Act*, which provides directions to Hospitals with respect to the provision of health care.

58. I was involved in the process relating to the revision and release of the OHA Midwifery Resource Manual on Hospital Integration. The OMA objected to the pro-midwifery language used in the draft OHA Manual. The OMA Submissions to the OHA on the then draft entitled "Midwifery Integration Toolkit for Hospitals" demonstrate that the OMA was concerned that the OHA Toolkit will undermine integration because it reads like "midwifery promotional material."[10] The OMA also objected to the highlighting of the autonomy of midwives and the unnecessary involvement of physicians in midwife-led births.[11]

59. On May 29, 2009 Jody Hendry informed TPAs that the OMP was working with the AOM, CMO and Ontario Hospital Association on updating and releasing the OHA Midwifery Resource Manual on Hospital Integration. The AOM had to negotiate for this correspondence in the 2008-09 negotiations to be sent by the Ministry to the TPAs so that TPAs would know that they are expected to support midwives to get hospital privileges (and not undermine them).[12]

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10 Midwifery Integration Toolkit for Hospitals" (2009/07) AOM0007505 – OMA Submission.

11 Midwifery Integration Toolkit for Hospitals" (2009/07) AOM0007505 – OMA Submission. See for example, p. 1, last paragraph on p. 4 concerning induction and p. 6, para. 3.

12 Memo to TPAs on Support for Midwifery Practice Groups (2009-05-29) MOH020903.

3. Caps on Midwifery Births

60. The Mount Sinai midwifery program was capped back in 2001 and has never changed since then. As a result of the cap on births, midwives have a visibility problem. We are not there all the time, so we get forgotten even though there are approximately 18 midwives. As an example, when a new epidural pump was recently installed no one remembered to train the midwives.

61. The Midwives Collective of Toronto could establish a second practice to address the enormous demand for midwifery care. The practice has lists of over 1000 unaccommodated requests for care every year.

4. MOHLTC System Barriers

62. I have firsthand knowledge of the effect of MOHLTC funding practices, including late approval of budgets and new registrants and Hospital restrictions on the ability of midwives to utilize all the courses of care allocated to them.

VII. EFFORTS TO COLLABORATE WITH PHYSICIANS

63. As a member of the AOM Policy Committee and AOM OMA Liaison Committee I was involved in working out the AOM's position and contributions with respect to a variety of difference legislative and policy initiatives and statements. This included the *Excellent Care For All Act* and the HPRAC review of professional scopes of practice.

1. Work with College of Family Physicians of Canada

64. I was the Canadian Association of Midwives representative from 2009 to 2012 on the College of Family Physicians of Canada's Maternal Newborn Care Committee.

65. A Joint Policy Statement on Normal Birth was issued in December 2008 by the Society of Obstetricians and Gynaecologists of Canada ("SOGC"), the Association of Women's Health, Obstetric and Neonatal Nurses of Canada ("AWHONN Canada"*), the Canadian Association of Midwives ("CAM"), the College of Family Physicians of Canada ("CFPC") and the Society of Rural Physicians of Canada ("SRPC").Noting the rise in caesarean section rates, the statement highlights the professional associations' concern about the increase of intervention during childbirth, as it introduces unnecessary risks for mother and baby. The statement cites research that social and cultural changes had fostered insecurity in women regarding their ability to give birth without technological intervention. Recommendations are included to support best practice and serve to promote, protect, and support normal birth.[13]

13 The Society of Obstetricians and Gynaecologists of Canada, the Association of Women's Health, Obstetric and Neonatal Nurses of Canada, the Canadian Association of Midwives, the College of

66. As the CAM representative on the College of Family Physicians of Canada Maternal Newborn Committee, I was involved in the preparation of CAM's additional statement on Normal Birth at that time which articulated the unique aspects of midwifery care which unfortunately had not been included in the Joint Statement despite our efforts. There are midwifery protocols which vary from physician protocols which were reflected in our separate statement which include affording pregnant women more room for choice of care, and technical matters such as timing for induction when post due date; management of group B strep and timing re: rupture of membranes.

Unfortunately, I was met with a hostile response from the SOGC representative on the above Committee who was offended that CAM felt it necessary to release its own statement. This is an example of a frequent lack of understanding by the medical community about the importance and value of midwifery autonomy and its unique and feminist approach to maternity care. Continuity, informed choice and choice of birthplace – hallmarks of midwifery care – all contribute to normal birth and excellent outcomes.

2. Work with Ontario Medical Association (OMA)

67. The focus of the AOM's OMA Liaison Committee was to create common ground. At the time I joined this group, the Committee was working on creating a joint statement on rural care and the importance of keeping birth close to home. The Committee approved a statement but the OMA board quashed it with no explanation.

68. The OMA-AOM Liaison Committee continues to meet regularly. I have been advised in those meetings by physicians that we should stop talking about our excellent midwifery outcomes as it “makes physicians look bad”.

69. When we brainstorm what we can do together, the only major area we seem to be able to agree fully on is getting higher fee codes for doctors dealing with referrals from midwives. This is very unfortunate as the AOM would like to have a more collaborative and productive relationship with the OMA. As well, there are significant numbers of physicians who do have good collaborative relationships with midwives and respect their model of care.

70. However, overall, the same systemic barriers seem to come up time and again – 1) many physicians and their representative organizations see birth as inherently risky and therefore often requiring their oversight and intervention, 2) physician

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Family Physicians of Canada and the Society of Rural Physicians of Canada, “Joint Policy Statement on Normal Childbirth”, December 2008 accessed at <http://sogc.org/wp-content/uploads/2013/01/gui221PS0812.pdf> AOM0016416 at p. 1.

competitiveness with midwives concerning midwives' excellent outcomes; and 3) physician interest in increasing their incomes. [14]

VIII. PURSUING MOHLTC FOR EQUITY IN COMPENSATION

1. Introduction

71. As a practising midwife, I followed the AOM's attempts to have our demand for pay equity heard by the Ministry. I was deeply frustrated by the MOHLTC's refusal to address the issue of equitable compensation appropriately.

2. 2004: Storks Don't Deliver Babies Campaign

72. In 2004 I actively participated in the "Storks Don't Deliver Babies Campaign." I saw the campaign as a way to respond to years of Ministry delays, inequitable compensation and to highlight our concerns about attrition. I called my MPP's office each time I was paged by my clients, even if it was in the middle of the night. I left many messages saying I was going to attend a birth or attend to urgent clinical work. Each time I told my MPP that I was not being properly compensated for that work. Midwifery consumers were also engaged in this campaign and provided communications supporting the AOM request.[15] [16]

73. During this time, a significant number of midwives were starting to consider leaving the profession and our inadequate compensation was a major factor. Our compensation did not support the unique demands and subsequent expenses of being an on call midwife. The extensive on-call requirements required us to incur substantial atypical expenses such as child care costs in the evening, nights and weekends, and on very short notice. Some midwifery families chose to solve the significant logistical dilemmas of on-call child care by having a parent at home, which then reduced the families' financial resources and ability to fund retirement and other family requirements. The AOM Benefits Trust reports that 35% of midwives are sole income earners; 48% are the primary income earner. 12% are single with dependent children.[17]

74. I recall during this time having ongoing conversations and debates with my fellow midwives about what could be done to make our voices heard. Ethically and morally, we were not prepared to stop providing care to women. It was against

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14 OMA Submission to OHA on draft document "Midwifery Integration Toolkit for Hospitals" (July 1, 2009) AOM0007505 at page 2, para 2.

15 AOM Consumer Bulletin #1 – Sustaining Midwifery (December 1, 2004) AOM0006280.

16 AOM template for calls to MPPs (2004) AOM0003067.

17 AOM Benefits Trust-2016 Plan Member Survey-What is your Household income status (2016-07-19) AOM0017355; AOM Benefits Trust- 2016 Plan Member Survey- What is your family status (2016-07-19) AOM0017354.

CMO requirements to do so and also we did not want our clients to suffer for what was the government's responsibility to provide equitable pay.

75. I had been planning on attending the December 14, 2004 AOM campaign rally and press conference that was to be covered by the CBC. That rally was ultimately cancelled. The AOM advised us that the MOHLTC had made an offer to increase the total midwifery program budget of $5.3 million in 2005-06; $8.0 million in 2006-07; and $9.0 million in 2007-08. This included money for the expansion of midwifery positions, increased compensation and other infrastructure costs. The AOM cancelled the rally and press conference when it received an offer in writing from the Ministry on December 13, 2004.[18]

76. Subsequently, we ended up negotiating with the MOHLTC a new contract which did provide us with an increase in compensation for the first time since 1994. This increase was limited by the amount which the MOHLTC had unilaterally decided in December, 2004 could be budgeted for this contract. While it was certainly not enough to provide equity, I voted for the contract as I understood that the MOHTLC also recognized the contract was just the first step in providing such equity to midwives. We were told that the MOHLTC could not afford to address all our equity concerns from being frozen for so many years in the first contract with an increase. Accordingly, while waiting for the next contract negotiations, the AOM worked on the Workload study discussed above.

3. 2008-2009 Negotiations and Agreement

77. The AOM and the MOHLTC entered into a new Memorandum of Understanding (MOU) signed May 7, 2009, which was to be in effect until March 21, 2011[19] The MOU provided for:

(a) an increase in the course of care fees of 2% annually as of April 1 of 2008, 2009;

(b) introduced the experience fee for rural/remote supplements and operational fee supplements for small rural or remote practices;

(c) increased the benefits from 18% to 20% of salary;

(d) introduced a professional development program similar to those long standing programs provided to physicians ("the CME program") and to other health professionals ("the Allied Health Fund"); and

18 Fax from Elana Johnson to all AOM members re: Press Conference Cancelled (Dec. 13, 2004) AOM0006273.

19 Memorandum of Understanding between Her Majesty the Queen in Right of Ontario as represented by the Ministry of Health and Long Term Care and the Association of Ontario Midwives (May 7, 2009) AOM0000617.

(e) included a parental leave program, a program already funded for several years by the Ministry for other health-care professionals.[20]

78. For me, the most important part of the offer was the commitment in Article 7 to jointly retain an objective independent third party to conduct a compensation review of midwifery services – to be completed prior to September 2010. This report was to recommend the appropriate "total compensation" for midwifery services based on available evidence "which will include, but will not be limited to: Comparable, relevant and historical compensation levels and factors of nurses, doctors and other relevant health care providers; Comparable and relevant midwifery compensation models in other jurisdictions; and The initial 1993 Morton compensation report and the February 2004 Hay compensation review report."[21] The MOHLTC had finally agreed to look at updated comparisons to the CHC physicians and senior primary care nurse/nurse practitioners which were used to assess our compensation for equity in these reports. Even though the Ministry would not agree to a binding process, I was hopeful that this would finally result in MOHLTC action to redress our pay inequity.

4. 2010 Onwards AOM-MOHLTC Negotiations

79. As AOM Vice President I became actively involved in government relations and the funding negotiations with the MOHLTC when the Midwifery Contracts and Funding Advisory Committee (MCFAC) was established in January 2012.

80. In 2011, the AOM's negotiations team had been dealing with constant delays in negotiations, refusal by the MOHLTC to implement the Courtyard report and assertions that compensation restraint policies should apply to midwives. At the same time, I learned that:

(a) the government signed an agreement with OPSEU that provided 2% wage increases for each of the four years for government workers and it also signed a separate, undisclosed agreement with OPSEU that provided for, granting them an extra percentage point — for a total of 3% — in 2012.[22]

(b) After completing with the male dominated OPP a three year deal from 2009-2011 for 2.34%, 2.25% and 2% (plus pension enhancements) and pay equity adjustments for those “outside of pay equity”,[23] the government

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20 Courtyard Report, AOM0000567 at pg. 29.

21 Memorandum of Understanding between Her Majesty the Queen in Right of Ontario as represented by the Ministry of Health and Long Term Care and the Association of Ontario Midwives (May 7, 2009) AOM0000617, Article 7.2.

22 Article in Globe and Mail re prison guard’s raise (May 23, 2011) AOM0000550.

23 OPPA Police salary negotiations update and other wage settlements (June 27, 2009) AOM0001486.

also had agreed to a 5.075% increase for the OPP for 2011, a salary freeze in 2012 and 2013 but then catch up in 2014 when they must be paid the same as the highest paid police in the province. In 2014, the government paid a first-class OPP constable with a high school education and six weeks of police college $87,240.[24]

(c) At the same time, the public learned that the government negotiated a 9.75% increase over three years for the male dominated corrections workers. This increase was given to incent low absenteeism, and was actually negotiated as the economic crisis began, but only came to light in May, 2011.[25] Also, the government provided a 6.5% increase over two years to the Ontario Power Generation engineers and scientists and other white-collar workers. And the medical officer of health was provided with equity resulting in, for example, a 12% raise for the Medical Officer in Kingston.[26]

81. All of these actions by the government made me feel that midwives were not valued as a highly female profession. We were not important enough to be prioritized for the equity adjustments we required. .

82. At the AOM's annual general meeting on May 9, 2011, which marked the start of my Vice Presidency, Health Minister Deb Matthews sent written “Minister’s Greetings” to the AOM again praising the role of midwifery in the health-care system but not addressing the pay inequity issue.[27]

83. We were becoming very tired of hearing that the Ministry valued midwifery but were not willing to translate that value into paying for the work equitably. At the above meeting, AOM members overwhelmingly passed a resolution to express their great disappointment and frustration. The resolution addressed the government’s unwillingness to acknowledge or address pay equity; its unwillingness to fairly compensate midwives based on based on a comparator of similar health care professionals, using criteria that includes scope of practice, education, on-call requirements, and responsibility for quality of client care and agreed to pursue various actions to protest and fight for pay equity.

84. The Ministry set up new AOM negotiation dates for May 24-26, 2011. These turned out to be the last negotiation dates until 2013. At that time, the AOM

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24 May 7 2013 Letter from R. Philbin, Superintendent Commander, Municipal Policing Bureau to Mayors of OPP Policed Municipalities regarding OPP Framework Agreement, AOM0006283. Antonella Artuso, “OPP can expect hike in 2014”, Sudbury Star (16 May 2011) accessed at <http://www.thesudburystar.com/2011/05/16/opp-can-expect-85-pay-hike-in-2014-6>

25 Article in Globe and Mail re prison guard’s raise (May 23, 2011) AOM0000550.

26 News Article from Kingston Whig Standard on April 19, 2011 re: Medical Officer of Health Pay Increase (April 19, 2011) AOM0001644.

27 Minister of Health and Long-Term Care, Greetings to Association of Ontario Midwives (May 2011) AOM0005379.

presented the Ministry with its summary of compensation increases that had been given to other public sector employees.

85. On June 1, 2011 I was one of more than 1,000 midwives and supporters rallied at Queen's Park. AOM President Kilroy made a speech entitled "You cannot separate the worth of women from the worth of midwives – "Rally for Pay Equity: Speech which I found very moving.[28]

86. Subsequently, I became involved directly in the negotiations when the Midwifery Contracts and Funding Advisory Committee (MCFAC) was established in January 2012 and it replaced the JMAC process.

87. The MCFAC Terms of Reference provided that the committee's purpose is to "to provide a forum for discussing issues and initiatives related to midwifery contracts and funding." It is chaired by the Director of Primary Health Care Branch and is to meet four times per year.[29] The AOM was represented by myself along with Lisa Weston, Juana Berinstein and Kelly Stadelbauer.

88. On February 13, 2012, MOHLTC ADM Fitzpatrick again extended the MOU. [30]

89. In May 2012, Lisa Weston took over as the new AOM President.

90. By letter dated June 26, 2012, Minister Matthews wrote to AOM President Lisa M. Weston concerning the "contract negotiations" but did not address the compensation inequities.[31] There were still no negotiation meetings. In the late summer and fall of 2012 the AOM repeatedly contacted the Ministry to express the urgent need for negotiations. We requested that the pay equity issue be dealt with by the creation of an objective and specific process to facilitate pay equity/wage parity. In doing so, we noted that "the midwifery profession, made up of female front line workers serving women clients, does not have access to labour legislation to mandate fairness, and therefore we rely on your government to negotiate fairly and in good faith with us, including negotiating in a timely manner." [32]

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28 Katrina Kilroy, Rally for Pay Equity Speech, delivered June 2, 2011, AOM0001621. See also Catherine Porter, "Ontario midwives rally for a raise they deserve", Toronto Star (2 June 2011) <www.ontariomidwives.ca/images/uploads/documents/thestaPorter.pdf>, AOM0000552. See also Association of Ontario Midwives, "Midwifery: Benefits to Hospitals and the Health Care System" AOM0005917.

29 MCFAC Terms of Reference" Schedule A, supra AOM0001090.

30 Letter dated March 29, 2012 from Mary Fleming, Director of Primary Health Care Branch to Kelly Stadelbauer, Executive Director of Association of Ontario Midwives, AOM0001671.

31 Letter dated June 26, 2012, from Deb Matthews, Minister of Health and Long-Term Care to Lisa Weston, President of Association of Ontario Midwives, MOH002035.

32 Letter dated September 27, 2012 from Lisa Weston, President of Association of Ontario Midwives to Premier McGuinty, AOM0006255.

5. Born Without a Contract (Fall 2012)

91. In October 2012, the AOM launched its "Born Without a Contract" campaign, urging the government to come to the table to negotiate a fair contract and address pay equity.[33] I participated in the campaign through posts to social media and working with clients who were involved in advocating for the issue.

92. The AOM conducted a provincial day of action dated October 19, 2012 with respect to the pay inequities facing Ontario's midwives. We continued to strongly object to the delays and to express the AOM's frustration with the lack of negotiations or a review process to address midwives' inequitable compensation. These delays were increasing the inequity which had been identified in the Courtyard Report.

93. Although I was not present for the meeting on December 4, 2012 I was in attendance at the MCFAC meeting on December 6, 2012 where we reiterated the need to implement the Courtyard report's 20% adjustment and in that context, would then agree to do our part to address the wage restraint policies after the appropriate equity adjustment had been made. We pointed out to the Ministry that midwives had been frozen from 1994 until 2005 and had already been restrained far more than others in the health care system. There was no need to control our compensation**.**

94. We had expected, as per the Minister's direction just two days prior, that a pay equity review, dates for negotiating a new contract, and issues relating to midwifery growth would be addressed by the MOHLTC's Melissa Farrell at that meeting. They were not. Farrell stated she was not given the direction that the AOM leadership had understood from the December 4 meeting with the Minister. The AOM requested that the Minister provide the direction in writing.

6. 2013 Negotiations

95. The Minister did provide a follow up letter to the December 4 meeting dated January 24, 2013 to AOM President Weston, stating:

(a) The Ministry could not agree to a binding compensation review and instead wished to discuss the Courtyard report.

(b) The Ministry has "concerns regarding the report" but "we strongly believe that midwives should be compensated fairly for what they do."

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33 The campaign was covered by Carol Mulligan of the Sudbury Star and included an interview with Cathy Fulton-Breathat, a midwife and AOM member. Carol Mulligan, "Ontario Midwives Rallying for New Contract", The Sudbury Star (22 October 2012) <www.thesudburystar.com/2012/10/22/ontario-midwives-rallying-to-ask-province-to-bargain-for-new-contract>

(c) The Ministry has “established the Midwifery Contracts and Funding Advisory Committee (MCFAC) where conversations regarding fair compensation will take place.”

(d) The 38% increase in compensation and increase in annual funding and increase in graduates.

(e) “Consistent with Ontario’s 2010 Budget Policy Statement and the 2012 Budget, transfer payment funding recipients across the province, including midwives have not received increases relating to compensation.”

(f) "The Government is continuing to ask all of its partners to continue restraint in order to help meet our fiscal targets and return to a balanced budget."

(g) The Ministry is not able to commit to a fee increase at this time. MCFAC is the process for changes in funding.

(h) The Ministry will establish two birth centres.[34]

96. There was a March MCFAC Meeting where the MOH continued to stall.[35]

97. In March 2013 the AOM wrote to Premier Kathleen Wynne and pointed out that contract negotiations and wage equity commitments remain unaddressed.[36] The AOM stated it was looking forward to working closely with the Premier to finalize the negotiations process and address wage parity.

98. In an April 18, 2013 MCFAC meeting, the issue of "wage parity," "Courtyard report questions" and "process and timeline to address wage parity" were on the agenda at the request of the AOM.[37] The AOM highlighted its concerns that the lack of regular good faith negotiations with set time frames had left midwives at a serious disadvantage with respect to their compensation, in achieving a mechanism for bringing issues forward and with respect to feeling valued and heard.[38] At the April 19, 2013 MCFAC meeting described below, the Director of Primary Care, Melissa Farrell stated that MCFAC was now to be the place where changes could be addressed. As the Government told us that they were not

34 Letter dated January 24, 2013 from Deb Matthews, Minister of Health and Long-Term Care to Lisa Weston, President of Association of Ontario Midwives, AOM0006169.

35 Midwifery Contracts and Funding Advisory Committee Minutes (March 18, 2013) MOH004864, at page 3, #6, 7 and 8.

36 Letter dated March 1 2013, from Lisa Weston, Kelly Stadelbauer and Juana Berinstein to Premier Kathleen Wynne, AOM0001704.

37 Midwifery Contracts and Funding Model Advisory Committee, Agenda, April 18, 2013, MOH002214.

38 Minutes from MCFAC Meeting on April 18, 2013 (April 18, 2013) MOH002215.

allowed to use the term “pay equity “ as it did not apply to our situation, we sometimes used the word “wage parity” with them in our discussions.

99. The AOM also indicated that it needed a dispute resolution process similar to the process afforded to the OMA by government in order to have equitable and effective negotiations.

100. I was very concerned at the approach of the Government because they were quite unilateral and dismissive in these meetings. At the MCFAC meeting on April 19, 2013, we were told that the Ministry had “evergreened” the contract and as a result, Ontario’s Midwives were not “working without a contract." We were concerned given the MOHLTC history of delays in negotiating, that an evergreen contract would mean there would never be an impetus to negotiate new terms.

101. We were very clear that the AOM would not consent to the “evergreening" as it was a unilateral action by the Ministry. Also, that since this was a unilateral action by the Ministry, that it would further erode the likelihood that the Ministry would address midwifery compensation issues in the future in a regular and timely manner.

102. The AOM again stressed the need to implement the Courtyard report recommendations. Melissa Farrell stated that the Ministry had concerns with the Courtyard report and they were not going to implement it. The AOM requested the Ministry note its concerns in writing. Farrell stated the Ministry was not willing to do so. [39]

103. We noted that jurisdictional comparisons were not relevant to a “pay equity” analysis, as the analysis was carried out based on pay equity criteria of SERW and not on what other jurisdictions paid to midwives. As well, comparing midwifery professionals in Ontario to other underpaid female midwifery professionals across Canada who are susceptible to gender discrimination in their wages for similar reasons as Ontario midwives is not an appropriate pay equity process.

104. We further responded to this by saying that the 20% gap would be a higher number now, and that the CHC physicians had since received increases and that the Quebec midwives had also received a pay equity adjustment.[40]

105. Melissa Farrell stated that the Ministry was not intending to review the Courtyard report as the report is now outdated and the Ministry would not be doing a new review. Once again, I realized the Ministry’s delays would be prejudicial to our ability to redress the pay equity gap.

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39 AOM Minutes of MFAC Meeting (April 19, 2013) MOH002217.

40 Pay Equity Commission Decision Re: Midwives 2010, Quebec, translated to English (December 7, 2010) AOM0002725.

106. We brought up Premier McGuinty's commitment to address pay equity 2.5 years ago and expressed the midwives' frustrations with the delays and inaction. Farrell's response was that that "we cannot commit to any increase." We repeated that the issue was a pay equity issue and asked whether the Ministry would engage in a process to address the issue. Farrell stated that there was no plan to do so. We told her that we would need to take other action if Ministry unwilling to address the equity issue.

107. By letter dated April 23, 2013, AOM President Lisa Weston wrote to MOHLTC Director of Primary Care Branch Farrell concerning the April 19, 2013 meeting stating:

(a) Midwives are frustrated by the lack of regular negotiations over the last 20 years and that there is no current indication that the Ministry's pattern is changing.

(b) "Midwives are not willing to accept that the pay equity gap, experienced as a female dominated profession, providing care to women, has no remedy. It is untenable for the Ministry to not acknowledge or concretely plan to address the gender-based discrimination faced by midwives" and made reference to rights under the *Human Rights Code*.

(c) The actions of the Ministry do not reflect Ministry statements that the Ministry values the contributions of midwives.

(d) "The Ministry must acknowledge and provide a concrete solution for ameliorating gender-based discrimination and the lack of contract that midwives have experienced which have resulted in a wage parity gap."

(e) "Midwives must have commitments to regular negotiations and access to arbitration if a decision cannot be reach at the negotiations table."

(f) That the Ministry provide a list of negotiation items for the next meeting on April 29, 2013.

(g) Re: wage parity – a commitment and concrete action plain with timelines for acknowledging and addressing the wage parity gap experienced by midwives as a female-dominated profession providing care to women who have not had access to regular good faith negotiations with the Ministry since 1995.

(h) Commitment to negotiation and access to arbitration – that the MOHLTC commit to negotiations in good faith no later than September 2014 to

negotiate needed changes to the contract that would come into effect on April 1, 2014. [41]

108. On April 29, 2013 Assistant Deputy Minister Susan Fitzpatrick, Phil Graham and Fredrika Scarth from the Ministry met with the AOM team, including myself for another MCFAC Negotiations meeting. ADM Fitzpatrick circulated a letter at that meeting that included a proposal.[42] The MOHLTC proposal to the AOM provided that the Ministry was unable to increase compensation because of restraints.

109. The above-noted letter referred to "pay increases," "compensation grid" and "compensation review" rather than to "fees" although it offers no increase. It also notes that the Courtyard report is not binding. The letter did not provide a detailed response to the Courtyard report. The letter connected the Ministry's reluctance to validate the report's recommendations to the government's compensation restraint policies. The letter includes investment in health care infrastructure such as growth in the number of midwives and the setting up "midwifery led settings" as relevant to compensation issues. While the MOHLTC states that it continues to value midwives, who play an "integral role in the province's health care system," the letter indicates it was not prepared to attach any compensation increase value to that contribution.[43]

110. At this meeting, I stated to ADM Susan Fitzpatrick that the Ministry was "inappropriately applying a broad compensation restraint mandate to a group that has been historically and systemically neglected."

111. When our policy director Juana Berinstein then raised in this meeting the "gender component to how midwives are compensated – pay equity" ADM Fitzpatrick responded: "This is not to be expressed as a pay equity issue – you know that – our lawyers will not allow us to speak about it as pay equity." Berinstein responded that while midwives were not technically covered by the *Pay Equity Act* as they were not employees, they were a female-dominated profession that needs an objective process to determine if its compensation is equitable. ADM Fitzpatrick responded: "I would caution against referring to this as pay equity – that legislation was referring to women working for the minimum wage and that isn't your situation. Some people could look at you and say that it is very fair compensation. If you compared yourself to a support worker, they could probably say yours is a very good compensation."

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41 Letter dated April 23, 2014 from Lisa Weston, AOM President to Melissa Farrell, Director of Primary Care, Ministry of Health, AOM0001707.

42 Letter from Susan Fitzpatrick, Assistant Deputy Minister at the Ministry of Health and Long-Term Care to the Association of Ontario Midwives (April 29, 2013) AOM0010078.

43 Letter dated April 29, 2013 from Susan Fitzpatrick, Assistant Deputy Minister, Negotiations and Accountability Management Division to Association of Ontario Midwives, AOM0010078.

112. After this I asked in the meeting if the Ministry could put in place a mechanism to look at the systemic underpayment based on gender and equity. Fitzpatrick advised that looking at the pay gap and implementing it are two separate things, and that the AOM would not want a second report that could not be implemented, stating words to the effect that (a)"not no money per se, there's a compensation policy." and (b)“pay equity isn't the route…I don't see a day when you are going to get your 20% increase but I do see a day when your increases will come about based on who needs the most and you'll probably be in a position to argue that you deserve a little more. I don't think the notion of catch up is realistic…I think a plan where you will get regular increases is more likely."

113. At this meeting ADM Fitzpatrick stated "the government is giving us no flexibility on negotiations. We cannot engage on that Courtyard report." "We have no ability to negotiate" with respect to the Courtyard report." There is to be "no budget growth" relating to 'compensation'. When Stadelbauer asked if it was the Ministry’s position that midwives are already paid fairly, Fitzpatrick stated that she did not think that was the Ministry's position, but that there was a need to get the budget under control. Fitzpatrick stated "You're going to have to wait."

114. Weston told Fitzpatrick that the membership felt very strongly that there is an issue of pay equity and that it will be moving forward through various process, legal and otherwise, to pursue pay equity.

115. The MOHLTC did not acknowledge or address the gender discrimination that I and other midwives have experienced as a female-dominated profession providing care to women and the way that this has contributed to a lack of negotiating power, lack of timely contracts and unfair compensation that does not adequately or fairly reflect the education, scope of practice, working conditions and level of responsibility of midwives.

116. The AOM reluctantly recommended that its members accept the Ministry offer and also pursue legal action to attain its member’s rights to pay equity as the only avenue of recourse given the Ministry's position. At the AOM’s Annual General Meeting on May 7, 2013, the AOM members overwhelmingly passed a resolution that stated:

> *“Ontario midwives once again express their deep disappointment and frustration that the Ontario government refuses to acknowledge and implement the recommendations of this Report;” and “Ontario Midwives once again express their shock and deep disappointment that the government has not acknowledged that this is a wage parity issue, and that Ontario midwives should be fairly compensated based on a comparator of similar health care professionals, using well-accepted job*

evaluation criteria that includes scope of practice, education, on-call requirements, and responsibility for quality of client care." [44]

117. On May 10, 2013, Weston wrote to Fitzpatrick:

We strongly disagree with the simplistic description of the background provided in your letter of April 29, 2013. There is an important distinction between a small annual compensation increase (which is what the government brought to the table in 2011 for year 3), and the necessity for wage parity adjustment as recommended by the Courtyard report. The former are increases that are contingent upon relative increases of other public sector workers, economic conditions, and cost of living changes while the latter is intended to correct for long standing discrimination experienced by a female-dominated profession providing care to women and infants. Cost of living increases are separate and distinct from the need to adjust wages for the sake of relative parity and the consistent erosion of midwifery compensation over the past twenty years relative to similar health care professionals. Your discussions and your letter of April 29, 2013 fail to appreciate this crucial distinction.

The small increase offered in 2011 for the third year of the contract did not address the wage parity gap, was contingent upon meeting targets, and yet again paled in comparison to the increases provided to other public sector workers at that time including physicians (5%, 3%, 4.25% 2009-2011, plus a $5,000 bonus to family physicians who provide labour and delivery to more than 5 women) and the OPP (5%, 0%, 0%, 8.5% 2012-2014, giving the OPP parity with the highest paid jurisdiction), thereby exacerbating the wage parity issue detailed in the Courtyard report. The government's "take it or leave it"' approach did not acknowledge or address the gender-based discrimination experienced by midwives in our contract negotiations; as expressed through a lack of regular negotiations, a lack of contract and compensation that is not aligned with their education, scope of practice, working conditions, or level of responsibility in Ontario's health care system.

From our initial negotiations meeting in October 2010, the Ministry has refused to discuss any recognition or implementation of the recommendations made in the 2010 Courtyard report. We understood, when agreeing in the Memorandum of Understanding of 2009 to undertake a compensation review, that this review would be a recommendation report. The extensive work that went into that report was done by both sides, including the Ministry, in good faith with the objective of arriving at data that both sides could rely on. It is almost three years later, and despite the Ministry's participation in the process, the report has

44 Letter from AOM Lisa Weston and Kelly Stadelbauer to Minister Deb Matthews re: failure of government to address the wage gap and need to bring legal action (2013-05-07) AOM0005761.

been ignored, shelved and dismissed by the government. Such behavior lends itself to the conclusion that the government agreed to undertake the review merely to delay the issue and never intended to enter into good faith contract negotiations with us on the issue of wage parity for midwives. As late as January of this year Minister Matthews wrote to us as follows:

"As discussed, the Ministry cannot commit to a binding compensation report. Rather it would be more prudent to review and discuss the existing report completed in 2010. As you are aware, the Ministry has concerns regarding the report, but we strongly believe that midwives should be fairly compensated for the work they do. The Ministry has established the MCFAC where conversations regarding fair compensation will take place."

And yet, our meetings subsequent to this letter (March 18, April 18, April 19 and April 29, 2013) have not yielded a good faith review and discussion of the existing report. We have seen no evidence that the Ministry is interested in such a review or discussion. In fact, as noted above, you stated that the government is not willing to commit to a process for wage parity adjustment as recommended by the Courtyard report and that the government is not willing to close the wage parity gap that currently exists for midwives. It is impossible to reconcile your statements with the Minister's letter.

At every turn over the last twenty years, midwives have been told to be patient and wait, and the situation of eroding compensation would be addressed. In 2005, then-Minister Smitherman told the AOM that although the inequity existed, it could not be addressed all at once; we would need to patient and wait for "the next time." We heard this from Minister Caplan in 2009, and we heard it from you again at Monday's meeting.

Midwives have been patient, collaborative, and offered various solutions to resolve the situation of fair compensation. We have met with staff in the Premier's office and the Health Minister's office to try to work with the government to find creative solutions to this difficult and long-standing issue in our contract negotiations. We understand that your answer to us on April 29 is the government's final word on this matter. As we are left with no other options, we will take any and all additional steps necessary to address the contract discrimination experienced by midwives.[45]

118. By letter dated May 27, 2013, Weston and Berinstein wrote to Premier Wynne advising that the AOM intended to recommend legal action against the government to address the inequitable compensation gap. The letter noted that,

45 Letter from AOM Lisa Weston to ADM Susan Fitzpatrick re: April 29, 2013 MCFAC meeting and government inaction and need to take action to address the contract discrimination experienced by midwives. (May 7, 2013) AOM0001706.

while the government acknowledged the gap, it refuses to constructively work with the AOM to address it. The AOM stated it would welcome a commitment on the Ministry's part to redress the compensation gap and failing that, the AOM would proceed with litigation.[46]

119. By letter dated May 27, 2013, Weston and Berinstein wrote to Minister Matthews:

(a) Contrary to the MOHLTC Minister's statement that it was prudent to review the Courtyard Group report, this had never happened and the Ministry had never come forward with explanations about all its concerns about the report or a plan to address any such concerns. The AOM noted that Ministry staff had contributed to the report, provided information, supervised the Courtyard consultants and agreed to the final draft.

(b) Contrary to the Minister's statement that the issue of fair compensation would take place in the MCFAC meetings, there had been no meaningful conversation about it and the Ministry, on April 29, 2013, had said that while it acknowledged the gap it was not going to redress it.

(c) As an almost exclusively female-dominated profession providing care to women, midwives are experiencing systemic gender-based discrimination with respect to our contract and this discrimination has resulted in a significant and growing compensation gap.[47]

120. As a result of the government's actions, we had exhausted our good faith efforts to persuade the Ministry to provide equitable compensation. Having warned the Ministry that we intended to seek a legal remedy for the pay inequity, the AOM signed the funding agreement dated June 3, 2013.

121. Midwives were in an impossible position. The contract did not uphold our rights and yet if we did not sign the contract, we would not be able to provide care, essentially jeopardizing the care of pregnant women and threatening their licensure, as the CMO defines withdrawal of care, or abandoning clients, as unprofessional conduct that can be disciplined.

122. As a result, we decided to prepare to pursue and file a Human Rights Complaint in order to obtain an adjudication of the human rights of midwives to compensation free of sex-based discrimination.

123. The Ministry cancelled the MCFAC meetings scheduled for June 12 and July 24, 2013. Premier Wynne responded by letter dated July 25, 2013 to the AOM's letter requesting that the Premier address the issue of midwifery inequitable

46 Letter dated May 27, 2013, from AOM's Lisa Weston and Juana Berinstein to Premier Wynne, supra AOM0001705.

47 Letter dated May 27, 2013, From Lisa Weston and Juana Berinstein to Deb Matthews, Minister of Health and Long-Term Care, AOM0007296.

compensation by referring the matter to Minister Matthews. Minister of Labour Yasir Naqvi in a letter to the AOM dated July 26, 2013 praised Ontario's *Pay Equity Act* as one of the most progressive statutes in the world but offered no pay equity redress mechanism for midwives.[48]

124. On September 9, 2013, the AOM met with Ministry representatives in a MCFAC meeting. The AOM requested dates for when formal negotiations would begin. The Ministry indicated that the AOM is not recognized as the bargaining agent for midwives and therefore there is no formal mechanism for compensation negotiation. That said, the Ministry stated that it was prepared to meet regarding future funding, but cannot discuss compensation increases until the government's compensation restraint policy is lifted. [49]

125. On September 23, 2013 Farrell sent an email to Stadelbauer suggesting that the AOM's legal counsel look at a government website that "provides information regarding union certification." [50]

126. By letter dated October 7, 2013, Weston and Stadelbauer wrote to Fitzpatrick, to express concern about the above-noted Ministry position and its contrast to the much more favourable bargaining process afforded to the male-dominated medical profession, represented by the OMA.[51]

127. Subsequently, the Ministry sent out the Template Funding Agreement to the TPAs without first getting agreement from the AOM on the changes it had made to the text. No such action would have been taken if the Ministry had been dealing with the OMA. This template included a change to the termination clause, creating an "evergreened" contract rather than a time limited contract. This change had not been discussed with the AOM and would have effectively eliminated the ability of midwives to ever again require the Ministry to meet with the AOM to discuss their contract.

128. On November 12, 2013, Lisa Weston of the AOM expressed strong concern in a letter to the Ministry's Melissa Farrell that the template had been sent to the

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48 Letter dated July 25, 2013 from Premier Kathleen Wynne to Lisa Weston and Juana Berinstein, Association of Ontario Midwives, AOM0002700; Letter dated July 26, 2013 from Yasir Naqvi, Minster of Labour to Lisa Weston, Kelly Stadelbauer and Juana Berinstein, Association of Ontario Midwives, AOM0000717.

49 Series of Documents from Midwifery Contracts and Funding Advisory Committee (MCFAC) dated September 9, 2013 to April 1, 2014 re: Agenda, Minutes, Proposals and Budget Request (April 2014) AOM0000801 at p. 7 para. 11.

50 Email dated September 23, 2013 from Melissa Farrell, Director, Primary Health Care to Kelly Stadelbauer, Association of Ontario Midwives, AOM0000718.

51 Letter dated October 7, 2013 from Lisa Weston and Kelly Stadelbauer, Association of Ontario Midwives to Susan Fitzpatrick, Assistant Deputy Minister- Negotiations and Accountability Management Division, MOH020435.

TPAs prior to finalization by both the AOM and the Ministry of this agreement. The AOM also noted that:

> *"On our review of this track-changes version, we note several items of the Funding Agreement that have been changed without discussion and certainly without our agreement. For example, one of these changes includes a clause that evergreens the Funding Agreement, which the AOM strongly opposed during our negotiation and which we continue to oppose. These unilateral changes have undermined our negotiation process and the AOM sees this as bad faith bargaining by the Ministry. We also note that this blatant move to make unilateral changes to the Funding Agreement following our negotiations is occurring after our notice to the Ministry that we are in the process of preparing an application to the Ontario Human Rights Tribunal regarding Ministry-set compensation that fails to provide pay equity or sex-based equal treatment with respect to employment and contracts."* [52]

129. Melissa Farrell responded on November 20 2013 with an apology for sending this template out prematurely, and with an explanation that it was sent because all of the changes to the template requested by the AOM had been made.[53]

130. Weston responded on November 26 2013 to Farrell and stated that:

> *"We do not agree with your description of the process or what happened. We remind you that both parties have always agreed that midwives are independent "contractors." By definition, therefore, the Ministry must "contract" with midwives. Contracts are agreements that are negotiated between the relevant parties. Legally they are composed of three necessary components - offer, acceptance and consideration. It is disingenuous to suggest that the Ministry inserted all the changes the AOM wanted and therefore felt free to unilaterally insert other clauses and then send those off as if there was agreement. Unilateral insertions into a draft contract by one party lack acceptance and are therefore considered to fatally undermine the agreement.*
>
> *Midwives in Ontario have mandated the AOM to be the body that negotiates their contract. The contract negotiated by the Ministry and the AOM is a template agreement that is then used by the TPAs and the Practice Groups. This is the established process that has always been used. Whether the government chooses to call these negotiations or*

52 Letter dated November 12 2013 from Lisa Weston and Kelly Stadelbauer AOM Executive Director, AOM President to Melissa Farrell, Director of Primary Care, Ministry of Health and Long-Term Care, AOM0007304.

53 Letter dated November 20, 2013 from Melissa Farrell Director of Primary Care, Ministry of Health and Long-Term Care to Lisa Weston, AOM President and Kelly Stadelbauer AOM Executive Director, MOH024664.

discussions, the fact is that the process we have always been engaged in is, by definition, negotiations. It is clear that the Ministry has failed to negotiate on a regular basis and that this has greatly disadvantaged midwives. It is also clear that the Ministry is inconsistent in its stance as to whether or not it is negotiating with midwives. Some years the Ministry admits, even insists, it is negotiating, other years the Ministry changes its mind and is not. There appears to be little rhyme or reason to this change of opinion. Regardless of how the Ministry currently characterizes the process, we are of the opinion that most courts would describe the process that has occurred in the past between the Ministry and the AOM as negotiations. That said such a process should never permit one party to unilaterally insert terms after agreement has been reached. This is a violation of the process and is unacceptable.

It is on this understanding that we object to your characterization of the process where you say that the agreement was sent out to the TPAs and the AOM simultaneously "because the Ministry had completed all of the changes in the template requested by the AOM." The fact is that, not only did the Ministry breach our agreement that the template would be provided to us for final review and approval, the Ministry unilaterally inserted important clauses that fundamentally changed the nature of the contract. We objected when you raised these issues during the negotiations. We continue to object. The Ministry's insertion of these clauses after agreement is a breach of good faith.

We cannot imagine that the Ministry would unilaterally make changes following the completion of negotiations with the OMA; we see this as yet another example of the inequitable treatment of midwives in the negotiations process.

If the Ministry has issues that it feels remain unresolved in this process then we suggest that the process needs to continue. We have a meeting scheduled for December 4th and the AOM is willing to engage with you further at this meeting. While your letter appears to be a threat that the draft agreement the Ministry distributed is take it or leave it, you may wish to reconsider endangering our relationship by threatening us with an ultimatum. Despite this, we remain open to continuing the negotiations at our upcoming meeting." [54]

131. At the December 4, 2013 meeting, Melissa Farrell again apologized for sending out the template agreement without first getting agreement from the AOM. Although we accepted Farrell's apology, we remained concerned that this was illustrative of the unwillingness of the MOHLTC to provide us with a proper

54 Letter dated November 26 2013 from Lisa Weston, AOM President and Kelly Stadelbauer AOM Executive Director to Melissa Farrell, Director of Primary Care, Ministry of Health and Long-Term Care

negotiation process as it did with the OMA. As Courtyard had noted, a proper and timely negotiation process was essential to getting fair compensation.

IX. MISCONCEPTIONS AND INVISIBILITY OF SKILLS, EFFORT, RESPONSIBILITY AND WORKING CONDITIONS OF MIDWIFERY

132. I believe that there are widespread misconceptions about the level of complexity and nature of work issues midwives deal with which are identified in our HRTO application. This includes the level of risk and complexity which midwives such as myself must address and manage in our practice.

133. For example:

(a) My clients are often from higher risk groups, for example women over 35 years old.

(b) At Mount Sinai, midwives work to their full scope of practice, including epidural and oxytocin. We transfer care for twins or breeches.

(c) I often give devastating news to a client about their pregnancy. At least once a week and sometimes more often, I have to talk a client and possibly her family though a miscarriage or some sort of negative result (ex: gestation diabetes, positive genetic result – decision making options such as pregnancy termination, birth plan isn't going to work)

(d) My work also draws on counselling skills such as screening for abuse, being aware of warning indicators and potential drug or alcohol use. When we are having those difficult conversations we must be constantly aware of cultural difference and communication styles.

(e) My work includes matters such as caring for those with medically complex histories which may not make pregnancy high risk, but requires knowledge and skill, in consultation with specialists (clients with thrombocytopenia, thyroid problems, mental health diagnoses, etc,)

Some Comments on the MOHLTC Expert Reports

134. Drawing on my knowledge teaching the Midwifery Education Program my AOM knowledge as well as my clinical experience, I clarify below a few of the many factual inaccuracies or omissions in the MOHLTC expert reports:

135. Chaykowski (2014) "Analysis of the Reports Supporting the Pay Equity Complaint by the Association of Midwives"

1. Context:

P. 22 2.4 (iv) (b)

(b) Midwives attach themselves to a midwife practice group, which is funded by a specific health sector Transfer Payment Agency; but midwives can and do change practice groups, so that the transfer payment agency that constitutes the source of their funding may change, as well.

136. **Clarification:** All of this is ultimately controlled by the MOHLTC; if the MOHLTC does not approve the growth of an existing practice group, or the start of a new MPG, those midwives do not have the autonomy to then move from their existing MPG. Also, the catchment area of any MPG in the province is controlled by the Ministry. The MPG is not free to pick up and move elsewhere in the province, nor is it able to decide to grow its catchment area.

137. **2. Context:**

charts on p 45: "Figure 6a Distribution of Primary Course of Care Loads 2012 - 2013 Fiscal year" and "Figure 6b: Distribution of Secondary Course of Care Loads 2012 - 2013 Fiscal year

138. **Clarification:** This chart excludes important context, including that there are:

(a) midwives just entering the profession part way through the year as a New Registrant (and therefore might have only a handful of cases billed in that fiscal year);

(b) retiring midwives winding down practice;

(c) midwives returning from or going on sick or parental leave a (would not have a full caseload)

(d) midwives with disabilities who are unable to work a full time caseload

(e) It also not clear whether it includes Caseload variables – if variables are provided for work, albeit not necessarily direct patient care work.

(f) Many midwives work on faculty at the Midwifery Education Program and are required by the universities to maintain an active practice while teaching in the midwifery program (therefore, part time faculty and part time clinician)

139. **3. Context:**

p 61 (iii) 2nd bullet The post-secondary program of study leading to physician includes a period of undergraduate studies of at least 3 years, the medical degree of 4 years, as well as a specialist program of study for family medicine of

2 years where CHC physicians are trained as family medicine practitioners; therefore the total postsecondary investment is typically in the range of 9-10 years;

140. **Clarification:** There is also a new registrant mentorship year for midwives required by the regulatory body which continues the clinical education of the new midwife.

141. **4. Context:**

p 64 footnote 131

That is, midwifery students attending Ryerson University from out-of-town would be expected to incur the same order of magnitude of costs of living as a medical student attending the University of Toronto from out-of-town; similarly, midwifery students attending McMaster University from out-of-town would be expected to incur the same order of magnitude of costs as a medical student attending the McMaster University from out-of-town; and midwifery students attending Laurentian University from out-of-town would be expected to incur the same order of magnitude of costs as a medical student attending Laurentian University from out-of-town.

p. 65 bullet 1&2 The overall direct cost of obtaining a medical degree is about four times that of a midwifery degree.

142. **Clarification:** There are additional expenses not accounted for by Chaykowski, These include that Midwifery students cannot choose where to do their clinical placements. Therefore they often incur out of town housing costs, travel and other costs. Further, Student Midwives earn nothing during their four year MEP and are unable to hold any employment concurrent with their clinical placements.

143. **5. Context: p.74** I expect the level of risk associated with a healthcare case, including cases of childbirth, to be a proxy for the level of effort, skill, and competency required to successfully provide the care required.

144. **Clarification:** The AOM has asked BORN for data related to low risk pregnancies. Low risk pregnancies account for 82% of all births attended by family doctors, and 86 % of all births attended by midwives. This is only a 4% difference.

145. This chart is the AOM's analysis of the data requested from BORN:

Fiscal year	Attending provider	All births by provider	Births to women with low-risk pregnancies	
		n	n	%
2013-2014	Midwife*	12673	10841	86
	Family physician	11663	9509	82
	Obstetrician	110305	69038	63
	Other healthcare provider†	2581	1932	75
	Missing	1697	1364	80
	Total	138919	92684	67
2012-2013	Midwife**	11793	10096	86
	Family physician	12248	10042	82
	Obstetrician	114410	72389	63
	Other healthcare provider†	943	620	66
	Missing	816	586	72
	Total	140210	93733	67

*Aboriginal midwife, registered midwife or midwifery student

** Aboriginal midwife or registered midwife

† Surgeon, registered nurse or other (includes EMS)

Notes:

While midwifery births for fiscal year 2013-4 are complete as of January 2015, some hospital births attended by other care providers had yet to be entered into the BORN Information System (BIS).

146. The criteria used to develop this low risk profile (that reflects the everyday practice of midwives):

Low-risk profile – additional information

The data request was designed to capture:

Live births between 37-42 completed weeks of gestation
All parity/all gravida
Spontaneous and induced labours
Singleton pregnancy
Cephalic presentation
≤ 1 Previous low segment cesarean section
Typically developing fetus
Normal placentation
Exclusion criteria

HDP
Eclampsia
HELLP
Preeclampsia
Preeclampsia requiring magnesium sulphate
Pre-existing HT with super imposed preeclampsia
Cardiovascular:
Congenital heart disease
Pre-existing HT
Pre-existing diabetes mellitus or insulin-dependent DM in pregnancy
Type I
Type II insulin
Type II no insulin
Serious health conditions
Autoimmune/lupus
Cancer indexed in pregnancy
Cancer
Renal disease
Cardiovascular disease
Labour and birth complications requiring immediate specialist care and/or surgery
Cord prolapse
Placental abruption
Retained placenta
Uterine rupture
Uterine dehiscence
Pulmonary embolism
Hysterectomy
Significant mental health concerns
Bipolar
Schizophrenia
Significant fetal concerns
Confirmed fetal anomalies
Isoimmunization
Abnormal placentation
Placenta acreta
Placenta increta
Placenta percreta
Placenta previa
Placenta Previa

*Certain complications, notably, IUGR, Polyhydramnios, Oligohydramnios, SGA, LGA, and all BMI values (including both high and low BMI) have been included rather than excluded as part of this “low risk profile”. This decision was based on a variety of factors. With conditions such as these, there is a spectrum of severity and a variation in the need for specialist management. While all of these conditions require a consultation with specialist care, a full transfer to specialist

care is only required in the most severe cases. Since the database does not report on this spectrum of severity, and since the majority of these cases remain in the management of non-specialist providers, these conditions have been included as part of the low-risk profile.

147. **6. Context:**

p. 80 2nd bullet There are few cost-effective alternatives to Ontario physicians (for example, attending a physician out-of-country is considered a possible but, typically, very costly substitution).

Clarification: This is also true for midwives; there are no direct substitutions (no provider in the system does the same work in the same way as midwives) and those that do would be a more costly substitution. It would also result in no attendance at out of hospital births.

1. Chaykowski. (2015) "Assessment of the Reply Reports of Mr. Durber, Mr. Mackenzie, Dr. Armstrong and Dr. Bourgeault"

1. Context:

p 30 para 54 (iv) The indirect opportunity costs associated with becoming a family medicine practitioner are at least twice as large as the costs incurred in becoming a midwife;

Clarification: There are also indirect opportunity costs associated with midwifery education, such as the cost of relocation and the loss of ability to earn income.

SWORN this 27th day of July 2016.

A Commissioner for taking Affidavits.

Elizabeth Brandeis